CLIENT SERVICE AGREEMENT

- We are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance, and your understanding of our payment policy.
- **INSURANCE PATIENTS** – The percentage of coverage by your insurance company may be based on your insurance company's own reduce fee schedule for medical services and may be less than actual charges, resulting in lower coverage for you. We have no control over this situation. Lower payment is a direct result of the plan selected by you or your employer.
- **INSURANCE** – This is a contract between you and your insurance company. We are not party to this contract. We will inform you if we participate with your insurance and will handle your claims according to our contract with that company. We file insurance claims as a courtesy to you. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered and non-covered services, or what charges are considered usual and customary.
  You are ultimately responsible for all charges whether or not paid by insurance.
- **ASSIGNMENT OF INSURANCE BENEFITS** – In the event that you are entitled to any benefits of any type whatsoever arising out of a policy insuring you or another party's liability to you, you hereby assign said benefits to AC Pediatric Dentistry (ACPD to be applied towards your bill. *If by any chance you received a check from your insurance company for our services you agree to forward the same to ACPD within 5 business days.*
- **PAYMENT** - All payments are due at the time services are rendered. We accept cash and personal checks. Returned checks are subject to a service charge of $25.00 or 5% of the face value, whichever is greater. Accounts not paid in full may accrue interest at the maximum rate allowed by law. In addition to the previous interest ACPD may charge a processing fee of $25.00 per month if your account is late or delinquent. In the case of default on payment you agree to pay any reasonable collection or attorney fees.
- **RETURNED CHECKS** – By signing this form, you authorize ACPD to initiate a debit entry to your checking account at your bank for the amount rendered on such returned check and an additional debit entry for $30.00 or legal maximum, whichever is less, if the item is dishonored. This authorization will remain in force until such time that a written notification, addressed to us, and signed by you or your legal representative is received.
- **APPOINTMENTS** – Office hours are by appointment only, call the office to schedule your appointments. To set up your first appointment please contact us at 305-825-9899.
- **CANCELLATIONS** - At the discretion of ACPD, late-cancels and no-shows may incur a charge that represents the full cost of your scheduled session. To prevent missed appointment charges patients must call 24 Hours prior to their appointment to cancel the appointment. Patients who do not cancel appointments, may be discharged from the practice after 3 missed appointments.
- **MULTIPLE VISITS** – Multiple visits are situations when a caregiver, parent or spouse attends session of one client but request a consult regarding a person other than the present client. These requests may be treated as a separate service with the corresponding fee.
- **COUNSELING/NEXT OF KIN SESSIONS** – Due to limited space only one person is authorized to accompany the patient. Additional sessions may be scheduled with the patient's authorization to explain the condition and treatment to relatives or a guardian. This is a separate visit and will be billed accordingly.

- **FORMS** – Patients requiring any type of form or paperwork to be filled must schedule an appointment with the provider. Specific forms must be provided by the patient and presented at the time of the visit. ACPD reserves the right to charge for faxes, copies, and filling of forms. Preparation, set up and copies of the medical record will result in a charge.
- **ON LINE COMMUNICATIONS CONSENT**- I acknowledge that I have read and fully understand ACPD's On line Communication Consent form. I understand the risks associated with the communication of online communications and consent to the conditions outlined. In addition, I agree to the instructions outlined as well as any other instructions that ACPD may impose to communicate via online communications. I have had a chance to ask any questions that I had and to receive answers.
- **BILIING ERRORS AND QUESTIONS** – If you think your bill is wrong, or if you need more information about a transaction on your account, write us on a separate sheet at the address listed on your bill. Items on the bill that are not in dispute or requiring further information, are considered due when the bill is received. We must hear from you in writing within 30 days from the original bill date if there are any questions or concerns. Otherwise the bill amount shall be considered accepted and entered as such on our books. In order to process your request properly we require a letter with your name and the account number, the dollar amount contested, and a brief description of the situation.
- In signing this form I consent to treatment by ACPD for my illness and/or health evaluation and agree that no guarantees have been made to me as to the results/outcome of my medical care. I also acknowledge that signature of this form may be used as a waiver of liability for such treatment.

I have read and fully understand the financial policy set forth by and I agree to the terms of this financial policy. I also understand and agree that the terms of the financial policy may be amended by ACPD at any time without prior notification.

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Signature of Client/Responsible Party **DATE**